Occupational Therapy

Outpatient Referral Form – Adult or Child

Fax: XXXX
Phone: XXXX

Date: 23/04/12	

MRN/PMI xxxx xxxx	SURNAME XXXX	OTHER NAMES Joan		M/F F
ADDRESS XXXX NSW			DOB XX/0X/19XX	ATSI
PH: Home XXXX	Work	Mobile (Parents if child)	GP: Dr XXXX	
REFERRER XXXX		POSITION/RELATIONSHIP Sister	Medicare/ DVA No.XXXX XXXX	
ORGANISATION Lives with sister		PH: As above	FAX n/a	
If child: MOTHER		FATHER	SCHOOL: YEAR:	

Diagnosis: Hypertension & severe epistaxis
CVA with (L) hemiparesis
Myocarditis (1977)

Other services involved in care?
Physiotherapist 3x week – gait & balance training with equipment

What service is being requested?

ADULTS	CHILDREN
☐ Upper Limb Therapy ☐ Cognitive/Perceptual Therapy ☐ Splint ☐ Other……..	☐ General developmental assessment ☐ Motor difficulties ☐ Handwriting assessment ☐ Other……

If for a home visit, please use community referral form.

What are the main difficulties and how are these difficulties impacting on daily living at home (and school/preschool for children)?

Difficulty with working in the kitchen

Any other comments?